PRINTED: 08/30/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPI	LETED
		155072	B. WIN		-	08/01/2	2011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		2002 AI	LBANY ST		
	GROVE MEADOWS			BEECH	I GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000							
			-		This was identified a second of the life.		1
		r Recertification and	F(	0000	This provider respectfully requests that the 2567 Plan	of	
	State Licensure	survey. This visit			Correction be considered the		
	included the inv	estigation of complaint #			Letter of Credible Allegation		
	IN00094241.				requests a Post Survey Rev		
					on or after 8/29/11.		
	Complaint IN00	094241 Substantiated, no					
		ted to the allegations are					
		ted to the anegations are					
	cited.						
	1	ly 25, 26, 27, 28, 29, and					
	August 1st, 2011						
	Facility number:	000029					
	Provider number	r: 155072					
	AIM number: 1	00275200					
		00276200					
	Survey team:						
	Leia Alley, RN,	TC					
	Marcy Smith, R						
	Barbara Hughes						
	· ·	W (July 25th thru 29th,					
	2011)						
	Courtney Mujic,	RN (July 28th & 29th,					
	2011)						
	Census bed type	:					
	SNF: 19						
	SNF/NF: 109						
	Residential: 13						
	Total: 141						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Census payor type:

Event ID:

3ZFE11

Facility ID:

000029

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155072	A. BUILDING		08/01/2011
			B. WINGSTREE	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		l	ALBANY ST	
BEECH (	GROVE MEADOWS		BEEC	CH GROVE, IN46107	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
_	Medicaid: 71				
	Medicare: 32				
	Other: 38				
	Total: 141				
	Sample: 24	1 1			
	Supplemental sar	nple: I			
	These deficiencie	es reflect state findings			
		ce with 410 IAC 16.2.			
ched in accordance with 410 IAC 10.2.					
	Quality review co	ompleted 8/5/11			
	Cathy Emswiller	RN			
F0242	The resident has t	he right to choose activities,			
SS=D	schedules, and he	alth care consistent with his			
		sessments, and plans of members of the community			
		tside the facility; and make			
	choices about asp	ects of his or her life in the			
		nificant to the resident.	F02.42	F 242 Calf datarmination ris	wht to 00/20/2011
		review and interview, the	F0242	F 242 Self determination, rig make choices. This provide	
	-	ensure residents were ect during night time		ensures that the resident ha	
	_	hem to awaken and take		right to choose activities, schedules, and health care	
		overnight showers. This		consistent with his or her	
	, ,	people interviewed for		interests, assessments and	
	_	ferences in a sample of		of care; interact with member the community both inside a	
	24.	•		outside the facility; and mak	
[	[Resident #'s 18 and 68]			choices about aspects of his	s or
				her life in the facility that are	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155072	A. BUII B. WIN	LDING		08/01/20	011
			B. WIN		ADDRESS CHEV STATE THE SORE		
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
		_		1	LBANY ST		
BEECH	GROVE MEADOWS	5		BEECH	I GROVE, IN46107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	Findings Include	<u>.</u>			significant to the resident. W	hat	
					corrective action(s) will be		
	1 D	: : : : : : : : : : : : : : : : : : :			accomplished for those resid	lents	
	1	erview with Resident #18			found to have been affected	· .	
	on 7/27/2011 at 2:15 p.m., she indicated				the deficient practice.Reside		
	she receives her showers very early in the				that reside in the facility are		
	morning. She indicated this is not her				risk for the deficient practice.		
		he feared she wouldn't be			Both residents, 18 and 68, w		
	1 *	wer if she didn't take one			interviewed to establish show time preferences. Shower time		
	1				were adjusted according to	iies	
	1	Certified Nursing			resident preferences, the tim	100	
	Assistant) sugge	sted she do so.			were then added to the resid		
					shower schedule. How will ye		
	During review o	f Resident #'s 18 "ASC-			identify other residents havin		
	Bath Type Detai	l Report", on 7/29/11 at			potential to be affected by th	- 1	
	1	cords indicated Residents			same deficient practice and		
	_				corrective action will be		
		owers in the early morning			taken.Facility will conduct an	audit	
	hours.				of all residents to ensure cur		
					shower times are acceptable	e, and	
	Early shower tin	nes for Resident #18			will be changed		
	were. 6/28/11 at	t 2:20 a.m., 7/5/11 at 1:57			accordingly. What measures		
	1	2:38 a.m., 7/20/11 at 3:42			be put into place or systemic		
		2.30 a.m., 7/20/11 at 3.42			changes you will make to en that the deficient practice do		
	a.m.				not recur. Nursing staff inserv		
					by Director of Nursing Service		
	2. Resident #68's	s record was reviewed on			on August 17, 18, and 19, 20		
	7/26/11 at 5:30 p	o.m.			about resident rights regarding		
	1				shower time preferences and		
	During an interv	iew with Resident #68 on			accurate documentation if		
	1 -	5 a.m., she indicated she			resident requests a time outs	side	
					of his or her original preferer		
		s very early in the			Interviews with residents bei	-	
	morning. She in	dicated this is not her			conducted to ensure shower		
	preference, how	ever this was when the			preference times are being		
	night shift nurse	was available to do her			met.Showers are being audit		
	1 -	she didn't want to go			daily for shower times. How t	ne	
	without the treat	<del>-</del>			corrective action(s) will be monitored to ensure the defi	ciont	
	without the fleat	mem.			practice will not recur i.e. w		

l '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		08/01/2	U11
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE		
				1	BANY ST		
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TAG	<b>.</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	f Resident #68 "ASC-			quality assurance program w put into place.CQI tool	/III be	
	1 **	Report", on 7/29/11 at			"Accommodation of needs" v	vill be	
	1 -	cords indicated Resident			completed weekly times 4,		
	#68 received sho	wers in the early morning			monthly times 2, and quarter	-	
	hours.				times 2. If threshold not met		
					action plan will be developed ensure corrective system is i		
	Early shower tim	nes for Resident #68 were			place.DNS or designee is	11	
	6/26/11 at 4:12 a	.m., 6/28/11 at 1:56 a.m.,			responsible for monitoring		
	7/8/11 at 4:29 a.r	m., 7/12/11 at 3:06 a.m.,			compliance. Any findings wil		
	7/13/11 at 1:50 a	.m., and 7/14/11 at 2:57			brought to the QA team on a		
	a.m.				monthly basis.		
	During an intervi	iew with the E.D.					
	1	etor) and DNS (Director					
	,	ces) on 7/29/11 at 4:30					
	1	ted they have a policy in					
	1 *	choice for shower times					
		onored. The DNS					
	1	she was made aware by					
		nt #68 is a person who					
	1 '	*					
	1 ^ ^	during night time hours					
		g day time hours and					
	prefers early mor	· ·					
		of residents preference to					
	1	as requested from the ED					
	1	9/11 at 4:45 p.m. As of					
	1	o further documentation					
	was provided.						
	1	on 8/1/11 at 1:45 p.m. a					
	facility policy reg	garding shower time					
	preference was re	equested from the ED.					
	The ED indicated	d the facility did not have					
	a written policy v	which addressed shower					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155072	B. WIN			08/01/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	LBANY ST		
BEECH (	GROVE MEADOWS	3		l	I GROVE, IN46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	preference time.						
	•						
	3.1-3(u)(1)						
	3.1 3(u)(1)						
F0253		rovide housekeeping and					
SS=E		ices necessary to maintain					
		, and comfortable interior.					
		ations and interview, the	F0	253	F253 Housekeeping and		08/29/2011
	facility failed to	maintain walls, ceiling,			Maintenance ServicesThis provider ensures that		
	equipment and fl	oors in good repair in 15			housekeeping and maintena	nce	
	of 20 resident roo	oms, affecting 27			services are provided to mail		
		g in rooms 101, 103, 105,			a sanitary, orderly and		
	_	28, 201, 205, 206, 207,			comfortable interior. What		
		nd 213 In 1 of 4 shower			corrective action(s) will be		
					accomplished for those resid		
		the facility failed to			found to have been affected	•	
	· · · · · · · · · · · · · · · · · · ·	and floors affecting 104			the deficient practice.Room for the cover was replaced for t		
	residents who uti	ilized these facilities			ceiling light in the bathroom		
					the air conditioner was	arra	
	Findings include	:			replaced.Room 107- The hol	es in	
					the wall have been repaired	and	
	I. During an envi	ironmental tour on			re-painted, the drapery tract		
	7/27/11 at 10:50				been repaired, the air conditi		
		pervisor, concerns			has been replaced, the ceilin		
		•			fixture in the bathroom has b replaced and the spackling o		
		lowing rooms were			ceiling has been painted.Roo		
	observed:				106- The window blind has b		
					replaced, the spackling unde		
	1. Room 103 - (2	2 residents). A			sink has been repainted and		
	fluorescent ceilin	ng light in the bathroom			walls in the bathroom have b		
	was missing it's o	cover and the air			cleaned.Shower Room E-F-		
	_	ed on the west wall of the			walls in the shower room hav		
		The second secon			been cleaned, the shower ro	om	

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155072  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPLI 08/01/20	ETED
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			2002 ALB	DRESS, CITY, STATE, ZIP CODE SANY ST GROVE, IN46107		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
2. Room 107 - (1 holes observed m and 5 X 6 inches the lower bottom east side of the rowest wall with 1 1 conditioner, and measuring 18 X 6 inches respective bed near the door ceiling for 10". A around the face o located on the we fixture in the bath with cracked space was unpainted.  3. Room 106 - (2 six slats of the with broken. The space underneath the bunpainted, and in dark colored marks.  4. Shower Room black matter was walls throughout area of the room 12 X 10 feet. A control with a broken with a broken with a broken with a broken wall behind the statement with a broken with a broken with a broken wall behind the statement with a broken with a b	resident). There were 2 heasuring 4 X 6 inches respectively, located on half of the wall on the bom, and 2 holes on the beneath the air 1 to the left of it, 6 inches and 24 X 5 ly. Drapery tract for the was loose from the a silver tape was used f the air conditioner est wall, and the ceiling broom was cracked along ckling on the ceiling that the area on the wall athroom sink was the bathroom there were			chair has been cleaned and a ceramic tiles at the base of the shower wall has been replaced Room 206- The spackling underneath the bathroom sinhas been re-painted. Room 2 Flaking paint has been removant area has been repainted. Room 207- The 4 hin the walls have been repaired and repainted. Room 201- The holes in the walls have been repaired and repainted. Room 128- The flooring in the bathrowill be replaced before 8/29/11. Room 105- The floor in the bathroom will be replaced before 8/29/11. Room 101- The flooring in the bathroom will be replaced before 8/29/11. Room 109- Flaking paint has been removed and area has been repainted. Room 328- The 5 hin the walls have been repair and repainted. Room 324- The flooring in the bathroom will be replaced before 8/29/11. Room 319- The flooring in the bathroom has been repaired. How will be replaced before 8/29/11. Room 213- The light fixture in the bathroom has been residents having the potential to be affected by the same deficient practice and corrective action will be taken Residents who reside in the facility are at risk for this alleg practice. What measures will put into place or systemic changes you will make to ensure that the deficient practice does the tha	the the ed.  kk 005- ved common ling ced che c	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155072	A. BUII B. WIN	LDING G		08/01/2011
	PROVIDER OR SUPPLIER		·	2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	.the base of the sith door, measure was interviewed and indicated 10 shower room at value of the shower regarding the following the shower of	hower stall wall, nearest ing 8 X 4 inches. RN #2 on 7/29/11 at 4:30 P.M. 14 residents use this various times.  Vironmental tour on P.M. with the pervisor, concerns lowing were observed: 2 residents). Spackling athroom sink was not a measuring 24 X 24  2 residents). Paint was all in an area covering 8 bathroom sink.  1 resident). There were 4 wall measuring 1/2 inches interview on 7/29/11 at			not recur.Room rounds will be conducted by managers were findings reported to maintent for repair or replacement. Managers to be in-serviced environmental room rounds Executive Director or design before 8-29-11 regarding utilization of work orders and the procedure for ensuring requests have been completed.Maintenance will 10 rooms per day for environmental concerns. Wo orders produced by room roof maintenance or managers be followed up on by Execut director to ensure timely completion. How the correctivaction(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be pinto place. CQI tool "Facility Enviornmental Review" will be completed weekly x 4, month 2 and quarterly x 2. If thresh not met, action plan will be developed to ensure the corrective systems are in place. Maintenance supervising designee is responsible for monitoring compliance. Any findings will be brought to the team on a monthly basis.	pe ekly, ance on by ee  r n audit rk unds s to ive ve o will ut pe hly x nold
1	the entryway.	·				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER					INSTRUCTION 00	(X3) DATE S COMPL	
		155072	A. BUII B. WIN			08/01/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BEECH (	GROVE MEADOWS	<b>,</b>		1	_BANY ST   GROVE, IN46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
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	6 Room 105 - (	2 residents). The tile					
	,	throom was discolored					
	around the toilet area measuring 36 X 24 inches.						
	7. Room 101 <b>-</b> (2	2 residents). The					
	`	the floor appeared to					
	have various fade	ed colors throughout the					
	room.						
	8 Room 109 - (2	2 residents). Paint was					
	,	e the sink on the wall in					
	the bathroom in a	an area measuring 15 X 8					
	inches.						
	9. Room 328 - (2	2 residents). There are 5					
	,	wall. One behind the					
		the room, measuring 24					
	· ·	holes were located					
		oard, of bed by the he room, measuring 2X					
	2 inches each.	ne room, measuring 2A					
	= memes each.						
		(2 residents). The vinyl					
	_	throom was discolored					
	for an area of 36 base of the toilet.	X 48 inches around the					
	base of the tollet.						
	11. Room 319 -	(1 resident). The flooring					
	under the bathroo						
		se and coming up in an					
	area measuring 2	4 A o inches.					

000029

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO  A. BUILDING  B. WING	00		E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN46107						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	12. Room 213 -	(2 residents). The fixture located on the							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155072	B. WING	ino		08/01/2	011
			1	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		- 1		BANY ST		
BEECH (	GROVE MEADOWS	3			GROVE, IN46107		
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F0279	A facility must use						
SS=D		velop, review and revise the					
	resident's comprei	hensive plan of care.					
	The facility must d	evelop a comprehensive					
	-	resident that includes					
		tives and timetables to meet					
	_	al, nursing, and mental and					
		ds that are identified in the					
	comprehensive as	sessment.					
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,						
		osocial well-being as					
		83.25; and any services that					
		e required under §483.25					
	but are not provide	ed due to the resident's					
		under §483.10, including the					
		tment under §483.10(b)(4).					
		review and interview, the	F02'	79	F 279 Develop Comprehensive Care Plans This provider ensures that the provider uses		08/29/2011
	facility failed to	ensure comprehensive					
	care plans were o	leveloped after being			the results of the assessmen		
	triggered by the	Care Area Assessments			develop, review and revise th		
	(CAA) for 3 of 9	9 residents reviewed for			resident's comprehensive pla	an of	
	, ,	ensive care plans in a			care.What corrective action(s	s) will	
	_ ·	esidents #17, #95 and			be accomplished for those		
	#106)	- Station III, 1170 und			residents found to have beer	1	
	11 100 <i>)</i>				affected by the deficient practice.Residents that residents	e in	
	Pin 1in 1 1	1.			the facility are at risk for this	C III	
	Findings include	a:			deficient practice.Resident		
					#17-care plan updated to inc	lude	
		Resident #17 was			mood and		
	reviewed on 7/28	3/11 at 2:20 p.m.			communication.Resident		
					#95-care plan updated to inc		
	Diagnoses for the	e resident included, but			psychosocial well-being.Resi # 106-care plan updated to	uent	
	were not limited to, depression and hard of hearing.				include vision and return to		
					community.How will you identify		
	<i></i>				other residents having the	,	

000029

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155072	B. WIN	G		08/01/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
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BEECH (	GROVE MEADOWS	3		BEECH	GROVE, IN46107		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					potential to be affected by the same deficient practice and		
	Review of a Sign	nificant Change MDS,			corrective action will be	wiiat	
	(Minimum Data	Set) (a Resident			taken.Facility will complete a	an	
	Assessment Instr	rument) dated 6/11/11			audit of residents who reside		
	indicated the resi	dent was tired a lot, had			within the facility to review a	nd	
	trouble sleeping	and was hard of hearing.			revise the resident's		
	The Care Area A	ssessments (CAA'S) for			comprehensive plans of care.What measures will be	nut	
		ted the resident should			into place or systemic chang		
	have a care plan	for mood and			you will make to ensure that		
		A review of the facilities			deficient practice does not		
		on their computer system			recur.MDS coordinator and		
	indicated care plans were to be written.  No care plans were found for mood or				Service staff inserviced by S		
					Development Coordinator or August 22, 2011 to ensure the		
	•	during the record review.			care plans are developed for		
	Communication	during the record review.			residents that trigger Care A	rea	
		: :4.4 D: 4 C			Assessments. Social Service		
	_	iew with the Director of			review other residents residi	-	
	_	(DNS) on 7/28/11 at 5:30			the facility to ensure care pla that are triggered by Care ar		
	•	rmation was requested			assessments are in place.Ho		
		k of care plans for mood			the corrective action(s) will be		
		n for Resident #17. On			monitored to ensure the defi		
		a.m. the DNS provided a			practice will not recur, i.e., w		
	care plan for Mo	od for the resident, with a			quality assurance program v put into place.CQI tool "Care		
	start date of 7/29	/11, and a care plan for			Updating" will be completed	; Flall	
	Communication	for the resident, with a			weekly x 4, monthly x 2 and		
	start date of 7/28	/11. She indicated they			quarterly x 2. If threshold no		
	had not been wri	tten prior to these dates.			met, action plan will be deve	•	
					to ensure the corrective syst are in place. DNS or designed		
	2. The record of	Resident #95 was			responsible for monitoring	; <del>C</del> 15	
	reviewed on 7/25	5/11 at 1:15 p.m.			compliance. Any findings wil	l be	
					brought to QA team on a mo		
	Diagnoses for the	e resident included, but			basis.		
		to, macular degeneration					
	and dementia wit	,					
	and dementia wit	ai nanacinadons.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 08/01/2	ETED	
NAME OF	PROVIDER OR SUPPLIEF	<b>  </b> 	D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
BEECH	GROVE MEADOWS	5			BANY ST GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Review of an initial Mood/Behavior/dated 6/20/11 into poor appetite. To indicated the resplan for psychostreview of the fact their computer steplan was to be we found for psychostreview. During an intervolve of the record review. During an intervolve of the record review. The record review of the record of plans for psychostreview of the record of reviewed on 7/20. Diagnoses for the were not limited diabetic neuropal Review of an initial indicated, according to the review of the record o	rial MDS Psychosocial assessment dicated the resident had a he CAA'S for this MDS ident should have a care ocial well-being. A silities "Work History" on ystem indicated a care ritten. No care plans were osocial well-being during w.  View with the DNS on o.m. further information egarding the lack of a care ocial well being Resident 1 at 10:00 a.m. the DNS olan for "overall well art date of 7/26/11. She not been written prior to  Fresident #106 was 6/11 at 9:00 a.m.  e resident included, but to, diabetes mellitus and thy.  tial MDS dated 6/1/11 ding to the CAA's, care					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	COMPLETED	
		155072	B. WING		08/01/2011
	PROVIDER OR SUPPLIER		2002	ET ADDRESS, CITY, STATE, ZIP CODE 2 ALBANY ST ECH GROVE, IN46107	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	During an intervity 7/26/11 at 7:00 p was requested replans for vision a community for R 7/2711 at 11:00 care plans for vision with the community with	esident #106. On a.m. the DNS provided ion and returning to the start dates of 7/27/11. by had not been written			
F0282 SS=D	facility must be pro- in accordance with plan of care. Based on observa- interview, the fac- therapeutic diet f as ordered by phy-	ed in a sample of 24.	F0282	F282 Services by qualified persons/per care plan. This provider ensures that service provided or arranged by the facility is provided by qualification persons in accordance with resident's written plan of care. What corrective actions be accomplished for those	ed each

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE S COMPL		
AND PLAN	OF CORRECTION		A. BUI	LDING	00		
		155072	B. WIN			08/01/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
DEECH				1	BANY ST		
	GROVE MEADOWS			BEECH	GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
IAU	REGULATORY OR	LESC IDENTIFYING INFORMATION)		IAG	residents found to have beer	,	DATE
	1 771 1: 1	1.C. D. :1 //10			affected by the deficient	'	
	1. The clinical record for Resident #12				practice.Residents that resid	e in	
		n 7/25/11 at 12:30 P.M.			the facility are at risk for the		
	Resident #12's d	iagnoses included, but			deficient practice.Resident#		
	was not limited t	to poor oral intake, and a			diet orders were evaluated b		
	review of weigh	ts indicated a 12% weight			RD and order was clarified p	er	
	loss from 5/4/11	to 6/7/11.			recommendations and physician.Resident # 6 diet o	rder	
					was reviewed by Dietary Clir		
	Review of the pl	hysician's order of 7/11/11			and meal ticket was		
	_	esident #12 be given 90			updated. How will you identif	y	
		d 3 X daily with meal			other residents having the		
		•			potential to be affected by the		
	1 *	f the physician's order			same deficient practice and	what	
		dicated that Resident #12			corrective action will be taken.Residents that reside i	n the	
		diet with fortified			facility have the potential to b		
		inch and supper, and may			affected by the alleged defici		
	have pleasure fo	ods (1 item with each			practice.Residents with		
	meal), and no flu	uids with pleasure foods,			therapeutic diet physician or	ders	
	and pudding thic	ck liquids. The physician's			were reviewed to ensure		
	order of 6/17/11	indicated the start of 1.5			compliance. No other resider were identified. What measur		
	Jevity continuou	s at 100 milliliters for 12			will be put into place or syste		
	hours to stabilize	e weight.			changes you will make to en		
		C			that the deficient practice do		
	During observat	ion of dinner on 7/26/11			not recur. Dietary Manager or		
	_	e resident was served 1			designee will in-service staff before August 29, 2011 rega		
	1	LPN #1 was assisting			reading tray cards and provide		
	Resident #12 wi				items as listed per tray	g	
		and indicated this			card.Dietary Manager or		
					designee will audit meal serv		
	1	nave been receiving a			accuracy, each meal 2 times		
	_	a liquid drink and a			week, concerning consistend meal per physician's orders.	•	
	1 ^	A review of the menu			interdisciplinary team will rev		
	given to the resident when served indicated one pureed item only be given			the physician telephone orde			
				Monday-Friday excluding ho	lidays		
	and no fluids.				and weekends to monitor alto		
					diet orders. Dietary technicia	an	

li ´		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		08/01/2	011
NAME OF	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER			2002 AI	LBANY ST		
	GROVE MEADOWS				I GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)		TAG	,	dataa	DATE
	DON was interviewed on 7/28/11 at 9:55				attends IDT meeting and upomeal ticket at that time. Wee		
	1	ated that resident should			manager will be responsible		
	1	food at meal time with a			reviewing orders and updatir		
	drink and a pleas	sure food.			meal tickets on the		
					weekend.Dietary Manager o		
	During an obser	vation of lunch on			designee will update any nev		
	1 -	5 P.M., Resident # 12 was			orders to the meal ticket dail: Monday-Friday excluding ho	•	
	served applesaud	ce and pudding.			and weekends. Weekend	iluays	
		1 5			Manager will be responsible	for	
	2 The clinical r	ecord for Resident #6 was			reviewing orders on the		
					weekend.All physician orders		
	reviewed on 7/26/11 at 9:45 A.M. Resident #6's diagnoses included, but was				altered diets have been audi		
		,			by Dietary Technician to ens meal tickets are accurate.Ho		
		bilitation, with a current			the corrective action(s) will b		
	_	of weight loss due to			monitored to ensure the defic		
	leaving 25 % of	meals uneaten.			practice will not recur, i.e., w		
					quality assurance program w		
	Review of physi	cian's order of 7/11/11			put into place.CQl tool "Meal		
	indicated Reside	ent #6 received a regular			Service Observation" will be completed weekly x 4, month	alv v	
	diet with ice crea	am at lunch and supper.			2 and quarterly x2. If thresho		
					not met, action plan will be		
	During observat	ion of dinner on 7/26/11			developed to ensure the		
	1 -	ident #6 was served a			corrective systems are in		
	regular diet with				place.Dietary Manager or		
	1 ~	interviewed and			designee is responsible for monitoring compliance. Any		
		es not receive ice cream			findings will be brought to the	e QA	
		neals. Resident #6 was			team on a monthly basis.		
	1	8/11 at 1:00 P.M. and did			_		
		ce cream with his meal.					
	1	lent #6 was observed at					
	6:10 P.M. and did not receive any ice						
	cream with his meal.						
	1	5 A.M., during interview					
	with DON, she i	ndicated resident #6					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED			
		155072	A. BUILDING B. WING		08/01/2011
	PROVIDER OR SUPPLIER		STREET 2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=E	and supper and if from the physicial ticket.  3.1-46(a)(2)  Each resident must must provide their to attain or maintal physical, mental, a in accordance with assessment and physical passed on record facility failed to records were most started for 4 of 5 bowel care in a showledge as well as the findings included the reviewed on 7/26. Diagnoses for Rebut were not limit renal failure, back mellitus.	review and interview, the ensure bowel movement nitored and interventions residents reviewed for ample of 24. (Residents and #87)  d:  Resident #106 was	F0309	F309 Provide care/services of highest well being. This provide care resident is provided the necessary care services to attain or maintain highest practical, physical, mand psychosocial well being corrective action(s) will be accomplished for those reside the deficient practice. Reside #106-Nursing completed a bassessment. Resident #91-Nursing completed a boassessment. Resident #95-Nursing completed a boassessment. Resident #87-Nursing completed a boassessment. Resident #87-Nursing completed a boassessment. Nursing staff in-serviced on bowel elimina policy. How will you identify residents having the potential	der s and the nental .What  dents by nt owel wel wel tion other

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		A. BUII	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING  B. WING  (X3) DATE SU  COMPLET  08/01/201			ETED	
	PROVIDER OR SUPPLIER		D. WIIW	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	indicated Resided Dulcolax supposed daily as needed in Review of the Market Resident #106 for indicated the resident #106 for indicated the resident #100 section titled "Dulcolax supposed and Blawas received from 7/27/11 at 11:00 section titled "Dulcolax supposed for Resident #100 for Review of a Connection Review of a Connection Review of a Connection Resident #106, for goal of "Resident #106, for goal of "Resid	dedication Records for or June and July, 2011, ident did not receive a sitory for constipation.  adder Chart Detail Report m the Administrator on a.m. Review of the chart id resident have a bowel cated a "no" was marked			be affected by the same def practice and what corrective action will be taken. The faci will complete an audit of res residing in the facility in order review alleged deficient practice. What measures will put into place or systemic changes you will make to enthat the deficient practice do not recur. Nursing staff to be in-serviced by Staff Develop coordinator on bowel elimina and documentation policy or before 8/29/11. DNS or designeviews bowel elimination reand documentation every dadayshift, Monday-Friday and appropriate ensures physicia orders are followed. How the corrective action(s) will be monitored to ensure the defipractice will not recur, i.e., with quality assurance program what into place. CQI tool "Bow Elimination" will be complete weekly x 4, monthly x 2, quaiting x 2. If threshold not met, action place. DNS or designee is responsible for monitoring compliance, any findings will brought to the QA team on a monthly basis.	ity idents idents ir to  be sure es ment ation n or gnee cord ny on l if ans cient that vill be el id irterly tion sure n	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MUL: A. BUILDI B. WING		00	(X3) DATE S COMPL 08/01/2	ETED	
	PROVIDER OR SUPPLIER		5	2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on 7/27/11 at 5:4 Resident #106 no 19 and 21 - 26. Of the DNS indicate information on b resident might ha administered.  2. The record of reviewed on 7/26  Diagnoses for Re were not limited pelvic fracture, for She was admitted  Review of a host dated 6/9/11, rec Development Co 4:50 p.m. indicate the hospital stay, constipation"  Review of recapi for July, 2011, in to receive Colace and Dulcolax 5 n These orders had 6/10/11.  A constipation ca dated 6/27/11, in	5 p.m. regarding of having a BM June 14 - on 7/28/11 at 10:00 a.m. od she had no further owel movements the ave had or laxatives  Resident #91 was					
		ys." Approaches					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155072	A. BUII B. WIN			08/01/2	011
	PROVIDER OR SUPPLIER GROVE MEADOWS			STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	included, but wer "Document abrotify MD"						
	Report was received Administrator on Review of the charcesident have a beindicated a "no" of Resident #91 on and 24, 2011, and 18 and 19, 2011.  Review of a MDS 6/20/11 indicated bowel.  Further information the Director of Non 7/27/11 at 5:4 Resident #91 not 24 and July 13 - a.m. the DNS indicated information on being the control of the property of	7/27/11 at 11:00 a.m. art section titled "Did owel movement" was marked for June 19, 20, 21, 22, 23 d July 13, 14, 15, 16, 17,  S for Resident #91, dated I she was continent of  on was requested from ursing Services (DNS) 5 p.m. regarding having a BM June 19 - 19. On 7/28/11 at 10:00 licated she had no further owel movements the					
	3. The record of reviewed on 7/25	Resident #95 was					
	were not limited	esident #95 included, but to, dementia with d chronic obstructive se.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MUL A. BUILD B. WING		NSTRUCTION  00	(X3) DATE S COMPL 08/01/2	ETED	
	PROVIDER OR SUPPLIER			2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	2011, with origin indicated Reside Metamucil capsu Magnesia 30 mil for constipation.  A constipation castarted 6/27/11, i "Resident will haleast [every] 3 daincluded, but we "Administer morderedmonito  A Bowel and Blawas received from 7/27/11 at 11:00 section titled "Dimovement" indicated for Resident #18, June 20, 21, 229, 30, July 1, 2, 10 and 11, 2011.  Review of a MD 6/20/11 indicated bowel.  Review of Medicand July, 2011 in	edications as r bowel function"  Idder Chart Detail Report m the Administrator on a.m. Review of the chart d resident have a bowel cated a "no" was marked 95 on June 14, 15, 16, 17, 22, 23, 24, 25, 26, 27, 28, 3, 4, 5, 6 and July 8, 9,  S for Resident #95, dated d she was continent of cation Records for June adicated Resident #95 did r Milk of Magnesia or					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLI		
		155072	A. BUI B. WIN			08/01/20	
NAME OF F	DROLUDED OD CLUDDI IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			1	BANY ST		
BEECH (	GROVE MEADOWS			BEECH	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFTING INFORMATION)	-	IAG			DATE
	Further informati	ion was requested from					
	the Director of Nursing Services (DNS) on 7/27/11 at 5:45 p.m. regarding						
		having a BM June 14 -					
		y 6 and July 8 - 11, 2011.					
	•	:00 a.m. the DNS					
	indicated she had	I no further information					
	on bowel movem	nents the resident might					
	have had or laxat	tives administered.					
		Resident #87 was					
	reviewed on 7/27	7/11 at 1:00 p.m.					
	Diagnasas for Do	ocident #97 included but					
	_	esident #87 included, but to, probable dementia,					
		drenal insufficiency.					
	depression and a	urchar insufficiency.					
	A recapitulated p	hysician's order for July,					
		ginal order date of					
		Resident #87 could					
		Magnesia, 30 milliliters					
	daily as needed f	or constipation.					
	•	pation care plan for					
	· · · · · · · · · · · · · · · · · · ·	iginally dated 10/14/10,					
	_	of "Resident will have					
		at least every 3rd day."					
	* *	ided, but were not					
	· ·	onitor bowel function					
	anAdminister r						
	_	MD if no BM after 3rd					
	day"						

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	ì í	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		2002 AI	ADDRESS, CITY, STATE, ZIP ( LBANY ST I GROVE, IN46107	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	was received fro 7/27/11 at 11:00 section titled "Di movement" indic for Resident #81 12, 13, 14, 15, 16 resident have a bindicated a "no" Resident 26, 27, 6, 7, 8, 9, 11, 12, Review of an Midated 5/18/11, in "frequently incomplete of Medicand July, 2011, in the receive any form of the Director of Non 7/27/11 at 5:4 Resident #87 not 11 - 17 and 26 - 13 and 11 - 16, 201 a.m. the DNS incomplete of the different might have administered.	28, 29, 2011 and July 5, 13, 14, 15 and 16, 2011.  DS for Resident #87, dicated she was ntinent" of bowel.  eation Records for June, ndicated Resident #87 did Milk of Magnesia for une and did not receive it				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155072		LDING	00		COMPL 08/01/2	
		100072	B. WI				00/01/2	UII
NAME OF P	PROVIDER OR SUPPLIER				DANIX OT	E, ZIP CODE		
BEECH (	GROVE MEADOWS			1	BANY ST GROVE, IN4610	7		
				<u> </u>	GINOVE, IN4010	ı		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLA (EACH CORRECTIVE A	N OF CORRECTION		(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED		E	DATE
1710		00 a.m., titled "Bowel		1110				DITTE
		ted 3/10, indicated						
	· · · · · · · · · · · · · · · · · · ·	policy of [name of						
		nsure that each resident						
		and healthy bowel						
		rnProcedure5. Bowel						
	_	be recorded on the						
		rd and/or resident care						
	<u>-</u>	he direct care staff. 6.						
		ee will assign a charge						
	•	ic shift to review all BM						
	-	y basis8. A resident not						
	having a bowel n							
	_	s, will be given a laxative						
		as prescribed by the						
		end of the 3rd day. 9.						
		having results from the						
	` '	softener will be given an						
		d by the physician. 10. If						
		oon, the resident (s) has						
	-	he nurse willnotify the						
	physician for fur	-						
	physician for full	mor orger.						
	3.1-37(a)							
	σ.1 σ/(α)							
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	3ZFE11	Facility I	D: 000029	If continuation sl	neet Pa	ge 23 of 38

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155072		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/01/2011		
	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
F0325 SS=D	Based on a reside assessment, the faresident - (1) Maintains acces nutritional status, so protein levels, unles condition demonst possible; and (2) Receives a the a nutritional problet 1. Based on interthe facility failed done weekly for resident's admiss reviewed for have for 4 weeks in a standard for 4 weeks in a standard for 4 weeks in a standard for 2 or in a sample of 24 [Residents' # 6 & Findings included 1. The record of reviewed on 7/28 Diagnoses for the but were not limit reflux disease and	nt's comprehensive acility must ensure that a speak parameters of such as body weight and east the resident's clinical rates that this is not rapeutic diet when there is em.  rview and record review, to ensure weights were 4 weeks following a ion for 1 of 12 residents ing weekly weights done sample 24. (Resident ervation, record review e facility failed to entic diet as ordered by f 12 residents reviewed extra the reviewed extr	F0	325	F325 Maintain Nutrition Stat Unless Unavoidable This provider ensures that reside maintain acceptable parame of nutritional status unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there nutritional problem. What corrective action(s) will be accomplished for those reside the deficient practice. Reside #125 weight remains stable will be weighted weekly x's 4Resident # 12 diet orders we evaluated by the RD and ord clarified per recommendation and physician. Resident #12 be weighed weekly x's 4.Resident wis stable. Nursing staff in-ser by Staff Development coordion the facility weight policy. Will you identify other resident having the potential to be aff by the same deficient practic and what corrective action we taken. Residents who residents.	nts ters ne dents by ent and vere der ns 2 will sident by cket eight viced inator dow nts fected ce vill be	08/29/2011

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155072	B. WIN	IG		08/01/2	011
NAME OF 1	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	BANY ST		
BEECH (	GROVE MEADOWS	5		BEECH	GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	•		DATE
		11. A care plan for the			facility are at risk for this alle deficient practice.What meas		
	1	lated 7/6/11, related to			will be put into place or syste		
	_	indicated approaches			changes you will make to en		
	which included,	but were not limited to,			that the deficient practice do	es	
	"Monitor weight	cs."			not recur.Residents will be		
					weighed per facility weight p		
	Review of a Wei	ghts Detail Report			Residents with therapeutic d orders will be reviewed on or		
	received from th	e MDS Coordinator			before 8/29/11 to ensure		
	(Minimum Data	Set) on 7/28/11 at 3:08			compliance.Tracking system		
	`	o weights had been done			developed to ensure		
	on Resident #12	_			compliance.New admissions		
					have weight obtained weekly weeks. New admission weight		
	During an interv	iew with DNS Specialist			will be reviewed weekly at	JIIIS	
	ı ~	9:20 a.m. she indicated			Nutritionally at Risk meeting	to	
					monitor residents weight loss		
		been done on Resident			gain.Dietary Clinician will ma		
	#125 since his ac	dmission on 7/11/11.			binder to ensure system is in	)	
					place. Dietary Manager will in-service dietary staff on or		
		dated as reviewed			before 8/29/11 to ensure that	t	
		from the Director of			proper items are being provide		
		s (DNS) on 7/27/11 at			per tray card for therapeutic		
		ted "Procedure The			diets.Nursing staff will be		
	1 -	et is to be maintained by			in-serviced by Staff Develope Coordinator on the weight	ment	
	the Nursing Dep	artment"			tracking policy on or before		
					8/29/11.How the corrective		
	During an interv	iew with the DNS on			action(s) will be monitored to		
	7/27/11 at 11:45	a.m., she indicated new			ensure the deficient practice	will	
	admissions are to	o be weighed weekly for			not recur, i.e., what quality		
		dicated Resident #125			assurance program will be p into place.CQI tool-"Residen		
	was weighed on	7/28/11.			Weights" will be completed b		
					Dietary Manager on day		
	On 7/28/11 at 12	2:30 p.m. the DNS			shift, weekly x 4, monthly x 2		
		tled document which she			quarterly x 2. If threshold no		
	l ^	oing to be the facility's			met, action plan will be deve to ensure the corrective syst		
	·	esident weights and			are in place. Any findings wil		
	I new policy for re	estuent weights and					

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) I		(X2) M	(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED	
		155072	B. WIN		-	08/01/2	011	
			D. 1711		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER				BANY ST			
BEECH (	GROVE MEADOWS				GROVE, IN46107			
				<u> </u>			775	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
IAU		·	-	IAU	brought to the QA team on a		DATE	
	1 ~	The document indicated			monthly basis.	1		
	"All admits/readmits will have an order stating 'Weekly Weights X 4 weeks."  2.a] The clinical record for Resident #12 was reviewed on 7/25/11 at 12:30 P.M.  Resident #12's diagnoses included, but				monany bacie.			
	was not limited t	o poor oral intake, and a						
	review of weight	s indicated a 12% weight						
	loss from 5/4/11	to 6/7/11.						
	The review of ph	sysician's order of 7/11/11						
	_	nt #12 be given 90						
		ds 3 X (times) daily with						
		· · · · · ·						
	1 -	review of physician's						
		11 indicated that the						
		given a puree diet with						
		s with lunch and supper,						
		k liquids, and may have a						
	pleasure food (1	item with each meal),						
	with no fluids. (	On 7/28/11, a list of						
	weights was prov	vided from 2/2011 to						
	7/2011 which inc	dicated a weight loss of						
	13 pounds (12%)	) from 5/4/2011 to						
		cian's order of 6/17/11						
	1	et of 1.5 Jevity continuous						
		for 12 hours to stabilize						
	weight.  During observation of dinner on 7/26/11							
	_							
		sident #12 was served 1						
		LPN #1 was assisting						
	Resident #12 wit	_						
	1 * *	, and indicated this						
	resident should h	ave been receiving a						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING  O  O  O  O  O  O  O  O  O  O  O  O  O		COM	COMPLETED 08/01/2011				
		100072	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	06/01/	2011
NAME OF I	PROVIDER OR SUPPLIER				BANY ST		
BEECH (	GROVE MEADOWS	3		1	GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
1710		a liquid drink and a		1710	·		DALE
	_	review of the menu					
	1 ^	t #12 when served					
	indicated one pur	reed item only be given					
	and no fluids.						
		terviewed on 7/28/11 at					
	· ·	ndicated Resident #12 pureed food at meal time					
	with a drink and	•					
	with a drink and	a picasare rood.					
	During an observation of lunch on 7/28/11 at 12:25 P.M., Resident # 12 was served						
	applesauce and p	oudding.					
	_	record for Resident #6					
		7/26/11 at 9:45 A.M.					
	not limited to del	gnoses included, but was					
	not minica to del	omtation.					
	Review of physic	cian's order of 7/11/11					
	indicated Reside	ent #6 received a regular					
	diet with ice crea	m at lunch and supper.					
		0.1:					
	"	on of dinner on 7/26/11					
	· ·	sident #6 was served a					
	-	no ice cream. Resident red at that time, and					
		does not receive ice					
		of his meals. Resident #6					
		7/28/11 at 1:00 P.M. and					
		ny ice cream with his					
		1 Resident #6 was					
	observed at 6:10	P.M. and did not receive					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	COMPL	
		155072	A. BUILDING B. WING	<del></del>	08/01/2	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		l l	LBANY ST		
BEECH (	GROVE MEADOWS	3	BEECH	H GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG	any ice cream wi		IAG	BEHELENCTY		DATE
	any ice cream wi	un ms mear.				
	with DON, she in should have rece and supper, and t	5 A.M., during interview ndicated that Resident #6 ived ice cream at lunch that it was not carried ysician order to the meal				
F0368 SS=F	provides at least the times comparable community.  There must be no between a substant breakfast the follow provided below.  The facility must oow When a nourishing bedtime, up to 16 a substantial even following day if a romeal span, and a Based on observations.	eives and the facility nree meals daily, at regular to normal mealtimes in the more than 14 hours ntial evening meal and wing day, except as  ffer snacks at bedtime daily. g snack is provided at hours may elapse between ing meal and breakfast the esident group agrees to this nourishing snack is served. ation and interview, the provide a nourishing	F0368	F368 Frequency Of Meals / Snacks At Bedtime This pro	ovider	08/29/2011

IDENTIFICATION NUMBER:   155072   155	STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS  SITERET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107  BEECH GROVE, IN46107  BEECH GROVE, IN46107  DEFINITION OF DEFICIENCIES PREFER (EACH DEPICIENCY MUST BE PERCEDED BY PULL) REGULATORY OR LSC IDENTIFYING INFORMATION)  Inight time snack to residents. This had the potential to effect 126 residents out of a total of 128 residents who received oral diets. [Residents 125, 68, 28]  Findings Include:  During an observation of the facility on 7/27/11 at 8:00 p.m., the A-C hall nurses station was observed. At the nurses station was observed. Buring in interview with Employee #4 on 7/27/11 at 8:15 p.m., he indicated the facility does normally pass out snacks, but there were some residents who had come to the nurses station to pick them up. He also indicated usually they would provide some type of snack for residents with diabetes, but at this time there were none available.  During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall  During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall  During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall  During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPI	LETED
STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE MEADOWS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSD IDENTIFYING INFORMATION)  night time snack to residents. This had the potential to effect 126 residents out of a total of 128 residents who received oral diets. [Residents 125, 68, 28]  Findings Include:  During an observation of the facility on 7/27/11 at 8:00 p.m., the A-C hall nurses station was observed. At the nurses station was observed. At the nurses station were 2 dining room trays with 10-15 fruit filled cookies and 2 pitchers of red "kool-aid" type of beverage.  During an interview with Employee #4 on 7/27/11 at 8:15 p.m., he indicated the facility does normally pass out snacks, but there were some residents who had come to the nurses station to pick them up. He also indicated usually they would provide some type of snack for residents with diabetes, but at this time there were none available.  STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN46107  PREFIX TAG REGULATORY OR LABANY ST BEECH GROVE, IN46107  TAG REGULATORY OR LABANY ST BEECH GROVE, IN46107  PREFIX TAG REGULATORY OR LABANY ST BEECH GROVE, IN46107  TAG REGULATORY OR LABANY ST BEPROPHENAIE COMPLETION CARCINGROMAL COMPLETION CA			155072	1			08/01/2	011
Description						ADDRESS, CITY, STATE, ZIP CODE		
Description	NAME OF P	PROVIDER OR SUPPLIER			2002 AI	LBANY ST		
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG Provides and offers nourishing snacks at bedtime daily to residents. What corrective action(s) will be accomplished for those residents. What corrective action(s) will be accomplished for those residents (what be accomplished for those residents (what corrective action(s) will be accomplished for those residents (what corrective action(s) will be accomplished for those residents. What corrective action(s) will be accomplished for those residents. What corrective action(s) will be accomplished for those residents. What corrective action(s) will be accomplished for those residents. What corrective action(s) will be accomplished for those residents who face the pean affected by the deficient practice. Residents #125, #68, #28 is offered a nourishing snack at bedtime daily. Oursing staff, Dietary Clinician and Dietary Manager in-serviced by Staff Development Coordinator regarding policy on HS snacks. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents who reside in the facility are at risk for this alleged deficient practice. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur. Nursing staff and Dietary staff will be in-serviced on or before 8/29/11 on providing snacks at bedtime daily. Dietary Manager will label all HS snacks required for the republic diets and assemble for delivery. Once delivered to unit dietary will	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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Findings Include:  During an observation of the facility on 7/27/11 at 8:00 p.m., the A-C hall nurses station was observed. At the nurses station were 2 dining room trays with 10-15 fruit filled cookies and 2 pitchers of red "kool-aid" type of beverage.  During an interview with Employee #4 on 7/27/11 at 8:15 p.m., he indicated the facility does normally pass out snacks, but there were some residents who had come to the nurses station to pick them up. He also indicated usually they would provide some type of snack for residents with diabetes, but at this time there were none available.  During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall  practice.Residents #125, #68, #28 is offered a nourishing snack at bedtime daily. Nursing staff, Dietary Clinician and Dietary Manager in-serviced by Staff Development Coordinator regarding policy on HS snacks. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents who reside in the facility are at risk for this alleged deficient practice. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur. Nursing staff and Dietary staff will be in-serviced on or before 8/29/11 on providing snacks at bedtime daily. Dietary Manager will label all HS snacks required for therapuetic diets and assemble for delivery. Once delivered to unit dietary will service where he were the size off the text.			,,,					
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to the nurses station to pick them up. He also indicated usually they would provide some type of snack for residents with diabetes, but at this time there were none available.  Changes you will make to ensure that the deficient practice does not recur. Nursing staff and Dietary staff will be in-serviced on or before 8/29/11 on providing snacks at bedtime daily. Dietary Manager will label all HS snacks required for therapuetic diets and assemble for delivery. Once delivered to unit dietary will			• •				be	
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available.  snacks at bedtime daily.Dietary Manager will label all HS snacks required for therapuetic diets and assemble for delivery.Once delivered to unit dietary will required to unit dietary will required to unit dietary will		some type of sna	ck for residents with					
During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall  Manager will label all HS snacks required for therapuetic diets and assemble for delivery. Once delivered to unit dietary will		diabetes, but at th	nis time there were none					
During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall required for therapuetic diets and assemble for delivery. Once delivered to unit dietary will		available.				· ·	-	
During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall assemble for delivery.Once delivered to unit dietary will						, ,		
7/27/11 at 8:25 p.m., the E and F hall delivered to unit dietary will		During an obser	vation of the facility on				anu	
7/27/11 at 0.25 p.m., the E dild I half		-						
nurses station was observed. At the		*				request Nursing to sign off the	nat	
nurses station was observed. At the snacks are available with a						snacks are available with a		
nurses station was 1 dining room tray with variety offered.Dietary Manager							-	
11 fruit filled cookies and 1 pitcher of red will monitor all snack items and			*					
"kool-aid" type of beverage.  track log sheets to ensure system		"kool-aid" type o	of beverage.				/stem	
is in place.Certified Nursing Assistants responsible for								
During an interview with Employee #3 on delivering and documenting if		During an intervi	iew with Employee #3 on				if	
7/27/11 at 8:30 p.m., she indicated she resident refused or accepted		_						
does not pass night time snacks. She snack in the Care Tracker		_						

Facility ID:

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 08/01/2	ETED	
REFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  indicated there were only a few cookies, and not everyone could have one, and she		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE  BANY ST  GROVE, IN46107  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  System. Nurse signs off that C.N.A. completed HS snack	08/01/2	(X5) COMPLETION DATE	
didn't feel it apprand not others. Staff only brough she would leave residents that wo one. She also indwere diabetic wo snack at bed time.  During an intervion 7/27/11 at 8:3 he never is offered told if he would nurses station. He never a very "healike to have some.  During an intervior 7/27/11 at 8:40 phad offered her a snack was availa.  During an intervior 7/27/11 at 9:00 pfacility never bricknew to go to the indicated every "	sopriate to offer to some She indicated the kitchen at out a few cookies so the snacks for the uld like to come and get dicated residents who suld not be receiving a e.  iew with Resident #125, 5 p.m., he indicated that ed a snack, he had been like he can find it at the le also indicated there is althy" snack and he would e fresh fruit.  iew with resident #68, on .m. she indicated no one e snack and didn't know a			requirementsHS snacks specifically given from a physorder are documented by a nurse. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be pinto place. CQI tool "HS Snacwill be completed by DNS or designee weekly x 4, monthl and quarterly x 2. If threshol met, action plan will be deve to ensure the corrective system are in place. Any findings will brought to the Quality Assura Team	will  ut cks"  y x 2 d not loped ems be		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED			
		155072	A. BUII B. WIN		<del></del>	08/01/2	011
	PROVIDER OR SUPPLIER  GROVE MEADOWS		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN46107		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	ID		**************************************		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F0371 SS=F	considered satisfal local authorities; a (2) Store, prepare, under sanitary con Based on observate facility failed to passed on observate facility failed to potential to affect who received medically facility f	distribute and serve food ditions ation and interview the prepare, distribute and sanitary conditions and to prepare food was anitary condition during servations. This had the tale of 128 residents als from the kitchen.	F0	371	F371 Food Procured/Stored/Prepared under sanitary conditions. This provimal store, prepare, and distril foods under sanitary conditions. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice. Residents who reside the facility are at risk for this alleged deficient practice. Howill you identify other resider having the potential to be affected by the same deficient practice and what corrective action we taken. Residents who reside facility are at risk for this alleged deficient practice. What meas will be put into place or system changes you will make to ensure that the deficient practice do not recur. Dietary Manager or designee will revise cleaning sheets to be more comprehensive. Dietary Manager or designee will monitor cleaton a daily basis to ensure cleaning is completed. Dietary Manager or designee will assadditional staff members to kitchen areas. Dietary staff witneserviced by dietary consult on facial hair policy prior to	ider bute  d for e t e in w ts ected e ill be sures mic sure es fining y sign clean ill be	08/29/2011

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	A. BUILI	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/01/2	ETED
NAME OF I	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	00/01/2	011
BEECH (	GROVE MEADOWS			BEECH	GROVE, IN46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	of dust, dirt, great and sticky to the 6. The three shell glasses, and silve accumulation of dry food crumbs 7. The large metal compartment simus killet and muffin accumulation of dry food crumbs 8. Two of two foof front and side sursticky to the touc 9. The plate warr food crumbs and 10. The tower call were stored had a dirt, greasy film, sticky to the touc 11. Kitchen service surface top was of flaking plastic. The control of the potential to a side were stored had a dirt, greasy film, sticky to the touch the potential to a side were stored had a dirt, greasy film, sticky to the touch the potential to a side were stored had a dirt, greasy film, sticky to the touch the potential to a side were stored had a dirt, greasy film, sticky to the touch the store to the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the side were stored had a dirt, greasy film, sticky to the touch the store that the side were stored had a dirt, greasy film, sticky to the touch the side were stored had a dirt, greasy film, sticky to the touch the side were stored had a dirt, greasy film, sticky to the touch the side were stored had a dirt, greasy film, sticky to the touch the side were stored had a dirt, greasy film, sticky to the side were stored had a dirt, greasy film, sticky to the side were stored had a dirt, greasy film, sticky to the side were stored had a dirt, greasy film, sticky to the side were stored had a dirt, greasy film, sticky to the side were store	f cart where the stored had accumulation sy film, dry food crumbs touch.  If cart where clean plates, erware were stored had dust, dirt, greasy film, and sticky to the touch.  If rack near the three k where pots, pans, a pans were stored had dust, dirt, greasy film, and sticky to the touch. The pans were stored had dust, dirt, greasy film, and sticky to the touch. The properties of accumulation of multiply color dry stains. The where oven sheet pans accumulation of dust, dry food crumbs and the liscolored, peeling, the handle and top had			8-29-11. Dietary staff to be in-serviced by dietary consu regarding sanitation on or be 8/29/11. How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be p into place. CQI tool-"Sanitation/Environment Review" will be completed b Dietary Manager or designed weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be deve to ensure the corrective syst are in place. Any findings will brought to the QA team on a monthly basis.	efore  will  ut  al  y the  e  ot  loped  ems  ll be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (COMPLETED)							
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155072	A. BUI		00	08/01/2	
		133072	B. WIN			00/01/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH (	GROVE MEADOWS			1	I GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	· · · · · · · · · · · · · · · · · · ·		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	On 7-29-11 at 6:	35 a.m. during breakfast					
	preparation and s	service the following					
	were observed:	C					
	12. Dietary Staff # 2 was observed to						
	have facial hair u	incovered, as he prepared					
	food, handled the	e dishes and served the					
	meal. He wore a	cover over his beard but					
	not his mustache						
	13. Dietary Staff	# 3 was observed to have					
	facial hair uncov	ered, as he handled the					
	dishes and served	d the meal. He wore a					
	cover around his	neck.					
	14. Dietary Staf	ff # 1 was observed to					
	have facial hair u	incovered, as he prepared					
	breakfast trays, h	andled dishes and served					
	the meal.						
	15. Dietary staff	# 4 was observed to wipe					
	a three shelf cart	off and leave food					
	crumbs on the sh	elf then place coffee					
	container and cup	ps on the shelf.					
		g equipment identified as					
		I during the dietary walk					
	~	d soiled on 7-29-11					
	during breakfast						
		oven used to prepare					
		umerous baked on spills.					
		cart had coffee container,					
	_	supplies had multiple dry					
	stains and food c						
		art where the microwave					
		ecumulation of dust, dirt,					
		food crumbs and sticky to					
	the touch.						

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING  B. WING		00	COMPL	
		155072	B. WIN			08/01/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEEGLIA				1	LBANY ST		
	GROVE MEADOWS	•		BEECH	I GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG			_	TAG	DEFICIENCY)		DATE
		cart where clean plates,					
	-	erware were stored had					
		dust, dirt, greasy film,					
	dry food crumbs and sticky to the touch.  The large metal rack near the three						
	1	k where pots, pans,					
		n pans were stored had					
		dust, dirt, greasy film,					
	*	and sticky to the touch.					
		I preparation tables front					
		were discolored and					
	sticky to the touc						
	_	r had accumulation of					
	food crumbs and	multiply color dry stains.					
	The tower cart w	here oven sheet pans					
	were stored had a	accumulation of dust,					
	dirt, greasy film,	dry food crumbs and					
	sticky to the touc	eh.					
	Kitchen serving	cart with plastic surface					
	top was discolore	ed, peeling, flaking					
	plastic. The hand	dle and top had					
	unidentifiable de	bris in the slits.					
	Interview with D	ietary Manager on					
	7-29-11 at 3:00 p	o.m. indicated it was the					
	facility policy that	at the dietary staff with					
	facial hair (musta	aches and beards) to be					
	covered when in	the kitchen. Facial hair					
	should be covere	d during handling,					
		erving food. Dietary					
	Manger indicated	_					
	"	rns had the potential to					
		residents who received					
	meals from the k						

	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	OF CORRECTION	155072	A. BUIL		00	08/01/2	
		1,000.1	B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				BANY ST		
BEECH (	GROVE MEADOWS				GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
F0465 SS=D	The facility must posanitary, and comfresidents, staff and Based on observational facility failed to erooms were in go doorway entranced of 2 washing maleaks.  Findings include:  During a tour of the 10:50 a.m., with the Supervisor, the foobserved:  1. In the primary near the front entercacked and unparameasuring appropriated and 18 X 18 inches coming loose from the service of t	the facility on 7/27/11 at the Maintenance ollowing concerns were dining room, located rance, the ceiling was	FO	465	F465 Safe/Functional/Sanitary/Cor able Enviornment. This provice ensures a safe, functional, sanitary and comfortable environment for residents, stand the public. What corrective action(s) will be accomplishe those residents found to have been affected by the deficient practice. The ceiling was repaired and repainted in the primary dining room. The ceiling above the machine was repaired and repainted. The double-doored entrance the southeast side of the built has been repaired. Repair quote obtained for washing machine. How will you identify other residents having the potentiate be affected by the same deficitly practice and what corrective action will be taken. Resident that reside in the facility are a risk for the alleged deficient.	mfort der  aff ve d for e t  g ice  on ding	DATE 08/29/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155072	B. WING		08/01/2011	
				ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			ALBANY ST		
BEECH (	GROVE MEADOWS			CH GROVE, IN46107		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	_		DATE
	2. The entrance	double doors located on		practice. What measures	will be	
	the southeast side	e of the building had a		put into place or systemic		
		inches wide X 36 inches		changes you will make to		
		g interview at that time,		that the deficient practice		
	-	-		not recur. Housekeeping a		
		Supervisor indicated that		laundry staff to be in-serv Maintenance Director on	-	
	these doors were	heavily used by		before 8/29/11 regarding		
	ambulance/transp	portation personnel and		load capacity of the wash		
	were planned to	be replaced.		machine, and proper sani	•	
	F 222.20			conditions of the laundry		
	2 In the loveder	magne lagated in the		and on how to fill out work		
	_	room, located in the		as needed. Executive Dir		
		washing machines was		receive a copy of work or		
	leaking and wet	towels were surrounding		follow up to ensure timely		
	the base of the m	achine. During an		completion by maintenan	e.How	
	interview with th	_		the corrective action(s) wi	ll be	
		at time, he indicated that		monitored to ensure the d	<b> </b>	
	-			practice will not recur, i.e.	· I	
		s on the 2012 budget to		quality assurance prograr	n will be	
	be replaced.			put into place.CQI		
				tool-"-"Sanitation/Environ	<b> </b>	
	3.1-19 (f)			Review" will be completed	·	
				Maintenance supervisor of		
				designee weekly x 4, mor and quarterly x 2. If thres		
				met, action plan will be de		
				to ensure the corrective s		
				are in place. Any findings		
				brought to the QA team o		
				monthly basis.		
R0000						
			R0000	This provider respectfully		
			110000	requests that the 2567 Pla	an of	
				Correction be considered		
				Letter of Credible Allegation	on and	
				requests a Post Survey R	eview	
				on or after 8/29/11.		
	This Residential	Finding is Cited in				
	Accordance with	410 IAC 16.2-5.				
		· <del>- ·</del>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING 00		COMPL	X3) DATE SURVEY  COMPLETED	
		155072	B. WIN	G	08/01/20		J11
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN46107				
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES			ID	DROWIDEDIS DE AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	(a) The facility share state of good reparts shall provide reason residents.  The facility shall a state of good reason and shall provide all residents.  Based on observation failed to maintain a direct in the residential laure residents who use the findings include:  During an environm with the Maintenance observations were must be made to the fallow of the fallo	all be clean, orderly, and in a ir, both inside and out, and onable comfort for all be clean, orderly, and in a pair, both inside and out, and onable comfort for all be clean, orderly, and in a pair, both inside and out, are reasonable comfort for an and interview, the facility clean and orderly environment andry room for 8 out of 13 is room to do their laundry.  The supervisor, the following made:  Laundry room, a liquid ext to the washing machine, was dripping a blue colored loor which had accumulated. Wheels, located against the machine, contained floor moperated by the door contained	RO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	y sures l, d nd nfort ive d for e the are nt  e what las nall l be sure es ndry	
		visor he could not identify the			in-serviced by maintenance		
	mop heads or cloths	as clean or dirty, but indicated			director on or before 8/29/11		
		is room to launder mop heads			regarding proper sanitary		
	and rags.	-			conditions of the laundry		
	-				room.How the corrective acti	` ′	
					will be monitored to ensure the		
					deficient practice will not recu	ur,	
					i.e., what quality assurance		
					program will be put into place	e.CQI	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  BEECH GROVE MEADOWS  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2002 ALBANY ST  BEECH GROVE, IN46107					
NAME OF PROVIDER OR SUPPLIER  2002 ALBANY ST					
1					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY).	COMPLETION				
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  Review" will be completed by the Maintenance supervisor or designee weekly x 4, monthly x 2 and quarteriy x2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. Any findings will be brought to the QA team on a monthly basis"	COMPLETION DATE				